Conclusion: Antibiotic prophylaxis in inguinal hernia repair was controversial. Although this is a small study, if representative of national prescribing practice the impact financially and clinically is significant.

0551: SEPSIS IN EMERGENCY SURGICAL PATIENTS: IS MANAGEMENT OPTIMAL?

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Aim: To assess if sepsis is recognised and appropriately managed in patients presenting as acute surgical admissions using the systemic inflammatory response syndrome (SIRS) criteria and Sepsis 6 as per Trust guidelines.
Methods: Data was collected over two weeks for all acute surgical admissions in a district general hospital. Medical notes and pathology results were reviewed for recognition and management of sepsis.
Results: 102 patients presented over two weeks. Only one patient had full documentation of assessment for SIRS criteria. The most frequently neglected criteria were mental state and glucose (not assessed in 83/102 and 98/102 respectively). Seven patients presented with sepsis; none had all 6 SIRS criteria documented; one had 5 documented; three had 4 documented; two had 3 documented; and one had 1 documented. None had the Sepsis 6 implemented within one hour. All were started on intravenous fluids, six were given antibiotics and five had lactate and full blood count measured. None were given supplementary oxygen.
Conclusion: This audit demonstrated the need for regular re-education on sepsis for all grades of doctors. The results have been presented locally, including re-education on Trust guidelines. A re-audit has taken place, with results available for presentation.

0591: SURGICAL SAFETY CHECKLIST COMPLIANCE: AN ASSESSMENT IN UK OPERATING THEATRES

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Aim: The World Health Organization (WHO) launched the Surgical Safety Checklist (SSC) to promote safer practice through facilitation of communication and teamwork among theatre staff; resulting in reduced surgical morbidity and mortality. Clinical governance reports demonstrated documentation was to a high standard, but direct observation of SSC checks suggested suboptimal quality.
This study aims to evaluate compliance to the WHO standard of the completion and accuracy of checks performed as part of the SSC.
Methods: An audit tool was developed to quantitatively evaluate compliance with SSC at multiple NHS hospitals. Trained observers performed qualitative assessment of team performance and non-technical factors at sign in, time out and sign out.
Results: Surgical and interventional radiology procedures (n = 100) were observed and audited across four hospitals (18 specialties). Checklist completion rates were high (mean 79.57%; range 56–100%), but accuracy of checks at all stages of checklist was poor (mean 42.33%; range 37–45%). Direct observations highlighted areas of weakness in team communication and cohesion.
Conclusion: Adherence and quality of SSC checks does not adequately meet the standards set by the WHO. Targeted training and education of theatre staff could enhance patient safety.

0607: IMPROVING PREVENTION OF VENOUS THROMBOEMBOLISM IN SURGICAL PATIENTS

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Aim: Venous thromboembolism (VTE) is the most common avoidable cause of hospital related mortality in the UK. However, administration of VTE prophylaxis remains globally poor. Our aim was to identify inadequacies in prescribing and administrating appropriate prophylaxis in acute and elective general surgical & orthopaedic in-patients and to address these concerns.
Methods: An audit of the prescription and administration of thromboembolic deterrent stockings and tinzaparin for VTE prophylaxis in acute and elective surgical in-patients was conducted over a 24-hour period using recommendation from NICE Guidelines.
Results: Of 57 patients, 42 patients (73%) were prescribed VTE prophylaxis. Of the 42 patients with adequate prescriptions, 29 patients (69%) received the appropriate prophylaxis. Of the 15 patients who were not prescribed prophylaxis, contraindications such as bleeding risk were documented in 6 patients (40%).
Conclusion: Despite hefty clinical emphasis on VTE prophylaxis, our results indicate that surgical patients are not being adequately protected against VTE. We recommended steps to be taken locally to educate clinical staff to ensure they are able to risk assess patients for VTE, record the outcome, prescribe and administer appropriate prophylaxis.

0632: OPERATIVE NOTES: AN AUDIT OF COMPLIANCE WITH THE ROYAL COLLEGE OF SURGEONS OF ENGLAND'S GUIDELINES ON OPERATIVE NOTES AT A SINGLE INSTITUTION

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Aim: The Royal College of Surgeons' (RCS) guidelines on operative notes outline the components of safe and comprehensive surgical records. We audited 50 operative notes against compliance with the RCS guidelines.
Methods: A retrospective audit of 50 operative notes from four surgical wards of one institution was performed on a single day in December 2014. This included all specialties with procedures within the last two weeks and available notes.
Results: No records met all of the RCS criteria.
All cases included date (although only 20% included the time), surgeon name and procedure. Details most frequently omitted were anaesthetist name (4%), estimated blood loss (4%) and anticipated blood loss (0%). Disparity between typed and hand written notes was evident. 9 of the 50 records were typed (18%). Details of time of surgery, detailed postoperative care instructions and prosthesis/implant identifiers were included in 100%, 100% and 60% of typed and 2%, 73% and 8% of handwritten notes respectively.
Conclusion: Operative notes are not meeting standards set by the RCS. Typed notes were more complete; this may facilitate more comprehensive and accessible records. Electronic notes and more detailed proformas may help to ensure that notes are completed. There is scope for re-audit.

0675: THE LOGISTIC AND ECONOMIC IMPACT OF SPECIAL STAGE RALLYING ON A GENERAL SURGERY DEPARTMENT DURING A MOTOR RALLY WEEKEND EVENT

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Aim: To identify the burden of injuries presenting to a general hospital during a 2 day Special Stage Rallying (SSR) event.
Methods: We prospectively recorded all patients presenting to the Emergency Department of a peripheral general hospital with injuries caused during a two day rally event. All patient demographics, history and examination findings, results of investigations and initial management required were recorded.We followed all patients until day of discharge to record all treatment required. We calculated the cumulative cost of bed days required for management of injuries.
Results: Eight patients presented to the ED (3 drivers, 2 navigators and 3 spectators; all male). 2 patients incurred soft tissue injuries and discharged by ED.One patient was directly transferred to the Orthopaedic Referral centre with a mid-foot dislocation. 5 patients were referred to the General Surgery (rib fracture, head injury, and 3 spinal fractures). 1 in 4 patients required surgical intervention and the average length of inpatient hospital stay was 4.125 days (range 0–9; total 24).€19,536 worth of hospital bed days were required for management of these injuries.